PATIENT QUESTIONNAIRE
Dr. Peter Bock, Facharzt für Orthopädie

Please fill in this questionnaire if you consult me the first time.
You will help me to gather important information (allergies, medication,..) which is relevant for your treatment.

What is the reason for your visit? _____

How did you hear about Dr. Bock? _____

PATIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth: _____ Title: _____

Insurance: ☐ GKK ☐ SVA ☐ BVA ☐ KFA ☐ other: _____

Austrian Social Insurance Number: _____ Private insurance: ☐ yes ☐ no

Street address: _____ Code / Town: _____

Phone number: _____ Email: _____

OTHER IMPORTANT QUESTIONS

Do you have allergies? ☐ yes ☐ no If yes, which allergies? _____

Do you suffer from diabetes? ☐ yes ☐ no

Do you take coagulation modifying medication? ☐ yes ☐ no
If yes, which? _____

Have you had any orthopedic or traumatologic surgery? ☐ yes ☐ no
If yes, which and when? _____

Do you take any dietary supplements? ☐ yes ☐ no
If yes, please specify _____

Do you take any other medication? ☐ yes ☐ no
If yes, please specify _____

Dr. Bock is looking forward to your visit. Please remember to bring any available x-ray, CT scan or MRI with you.